New Application

Michigan Department of Community Health
Michigan Drug Assistance Program (MIDAP)

2015 New Application

v.15.0 All Previous Versions Obsolete

Demographic Information: Please Print.
NOTE: Proof of residency must be attached. **All applicant information will be sent to the address entered below.**

1. Have you ever been on MIDAP? If yes and you know your Member ID, please write it here:_____

2. Legal Last Name: _____ **Legal First Name:**_____

Legal Middle Name:_____ **Maiden Name:**_____

Alias: _____ **2. Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

3. Address:_____ **APT #:**_____ **City:**_____

State: MI **Zip Code:** _____ **County:** _____ **4. Phone Number:** (___)_____

5. Social Security Number:_____-_____-_____ **6. Date of Birth: :** _____ /_____ /_____

7. Sex at Birth: ☐ Male ☐ Female

8. Current Gender: ☐ Male ☐ Female ☐ Transgender

9. Transgender Status: ☐ Male to Female ☐ Female to Male ☐ Unknown

10. Are you currently pregnant?

☐ Yes If yes, when is your due date: ____/____/_____ ☐ No ☐ Not Applicable ☐ Unknown

11. Race: (One or more categories may be selected):

☐ White ☐ Black or African American ☐ American Indian or Alaska Native

☐ Native Hawaiian/Pacific Islander (Select one or more subcategories that apply below):
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander

☐ Asian (Select one or more subcategories that apply below):
☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian

12. Ethnicity (Select one of the following):

☐ Hispanic/Latino ☐ Non-Hispanic ☐ Unknown

If you are of Hispanic, Latino/a, or Spanish origin, select one or more subcategories that apply below:

☐ Mexican, Mexican American, Chicano/a ☐ Cuban
☐ Another Hispanic, Latino/a or Spanish Origin ☐ Puerto Rican

Status and Date of Disease:

13. Estimated HIV Positive Date/Diagnosis: _____/_____/_____

14. Name of HIV test (If known): _____

15. Estimated AIDS Positive Date, if applicable: _____/_____/_____

16. HIV Stage of Disease: (Check one):

☐ HIV-positive, AIDS status unknown

☐ HIV-positive, not AIDS

☐ CDC defined-AIDS (3rd Stage HIV)

☐ Unknown

17. Household Size and Income:

Household Size:_____ (Include yourself and any other joint income- including your legal spouse and dependents living with you)

Did you receive income from any of the following sources? If yes, check all that apply and indicate the amount on the line to the right in **MONTHLY** totals. **Proof of income must be attached to the application.**

☐ Employment Income (Gross): _____

☐ Self-Employment: _____

☐ Unemployment: _____

☐ Social Security Income: _____

☐ Supplemental Security Income: _____

☐ Public Assistance: _____

☐ Pension: _____

☐ Retirement: _____

☐ Other: _____

☐ Gross **Annual** Income: _____

☐ No Income: If checked, complete information below

Date of DHS application:_____/_____/_____

Must also apply for DHS benefits prior to applying for MIDAP Full Prescription Coverage.

18. Proof of HIV Status:

This section **must be filled in** with the most recent lab values. Attach laboratory proof of status results to completed application.

Absolute CD4 Count: _____ Date of most recent test result: _____/_____/_____

HIV RNA/Viral Load: _____ Date of most recent test result: _____/_____/_____

If laboratory results are not immediately available, please have your physician or his/her designee (as allowed under Michigan law) sign to receive 30 days of temporary coverage.

Physician/Designee Name (Print): _____ Physician/Designee Signature: _____

Physician NPI Number: _____

If signing as Designee, please print the physicians name: _____

19. Prescription/Medical Insurance Coverage: Please see checklist provided for all required supporting documentation. A copy of your insurance card must be attached for accuracy.

Do you have prescription coverage/medical insurance through any of the following that require you to pay a copay and/or deductible at the pharmacy?

☐ No (Move on to the MIDAP Coverage section) Please Note: **Must apply for DHS benefits prior to applying for MIDAP Full Prescription Coverage (Uninsured).**

☐ Yes (Check all that apply below and provide addition information)

☐ Employer Sponsored Insurance (Including COBRA)	Name of Carrier: _____
☐ Private Policy (Paid for by you or other entity)	ID Number: _____ RxBin No. _____
☐ Qualified Health Plan (Marketplace)	RxPCN No. _____ RxGroup No. _____
	Plan Start Date: _____/_____/_____
☐ Medicare Part A/B	ID Number: _____
	Part A Start Date: _____/_____/_____
	Part B Start Date: _____/_____/_____
☐ Medicare Part D or Advantage	Name of Carrier: _____
	ID Number: _____ RxBin No. _____
	RxPCN No. _____ RxGroup No._____
	Plan Start Date: _____/_____/_____
☐ Veteran's Administration Benefits (VA)	VA Location/City where you receive care: _____
☐ No Insurance	
☐ Other	

20. MIDAP Coverage: Please indicate the type of MIDAP Coverage you are requesting (Check only ONE)

☐ Full Drug Assistance:	If you have no additional insurance (Uninsured)
☐ Copay Assistance:	☐ Private ☐ Qualified Health Plan ☐ Employer Sponsored ☐ COBRA ☐ Veteran's Assistance
☐ Medicare Copay Assistance:	☐ Medicare Part D ☐ Advantage Plan (Part C)

Incomplete applications and/or missing information will not be accepted and/or will delay processing.
All incomplete applications will only be held for 45 days.

Consent Form/Authorization for Release of Information
Michigan Department of Community Health
HIV/AIDS Drug Assistance Program

By signing this consent, I authorize the Michigan Department of Community Health – HIV/AIDS Drug Assistance Program (MIDAP) to share, receive, disclose, and discuss medical information related to the care and treatment of my HIV infection with any health insurance or government health insurance program, case manager, physician, infectious disease doctor, or other individuals required.

I understand that the information I have provided on this application will be shared with other government agencies, health insurance companies and/or the contracted pharmacy benefits manager for the purpose of verifying the accuracy of the information provided and in determining my eligibility in MIDAP and/or other programs that I may be eligible for.

I understand that if I become enrolled in a health insurance program, prescription coverage program or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify MIDAP in addition to my case manager, pharmacist and physician.

I understand and agree to submit periodic information regarding my continued eligibility for MIDAP, including proof of income, proof of residency, health insurance coverage, and general updates on forms provided by the MIDAP program. I understand that changes in my situation will be evaluated to determine my continued eligibility for MIDAP.

I understand it is my responsibility to provide medical and proof of income every six months to recertify as eligible for MIDAP to receive assistance with my medications. I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval, I will not be eligible for assistance until all of the requirements are met.

I understand that if any of the information provided on this application changes, that I must notify MIDAP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information will affect MIDAP coverage and program eligibility.

I understand that by utilizing MIDAP for medication assistance and by filling prescriptions, using my SGRX/MIDAP card that I have read all of the MIDAP Policies and Procedures and I am agreeing to abide by them.

I understand that MIDAP is not insurance and is not valid outside the State of Michigan.

The information that I have provided on this application is true and complete to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the MIDAP Instructions and have followed the necessary steps that are required for me to be eligible for MIDAP.

This application, when completed, contains confidential information that must be protected under applicable federal and state confidentiality laws.

_____ _____

Print Full Legal Name (First, Middle, Last) Date

_____

Signature of Applicant

_____ _____ (___) _____

Print Name (Case Manager, if applicable) Agency Phone Number

Mail or fax completed application and all supporting documentation to:
Michigan Drug Assistance Program
109 W. Michigan Ave. 9th Floor
Lansing, MI 48913
Phone: 1-888-826-6565 - Fax: (517) 373-1495

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

HIV/AIDS MICHIGAN DRUG ASSISTANCE PROGRAM

ELIGIBILITY CRITERIA – 2015

To receive prescription coverage from the Michigan Drug Assistance Program (MIDAP), applicants must meet the following criteria:

A. Must provide documentation of HIV disease (see Page 7, Number 17).

B. Applicant must be a resident of the State of Michigan. Proof of residency must be attached to the application. See number 4, page 6 for more detailed information on how this must be provided.

C. In some cases, applicant must have applied for public assistance (Medicaid and/or the Healthy Michigan Plan) with the Department of Human Services (DHS) within the past 90 days and have a pending, denial, or spend-down status.

D. Applicant's monthly/annual gross income cannot exceed 450% of the Federal Poverty Level (F.P.L.) and will be evaluated based on FPL guidelines (see chart below) in effect when MIDAP receives your completed application. Earned Income and/or Unearned Income (income from employment or self-employment, SSI, SSDI, disability etc.)

In all instances, MIDAP is to be considered the payer of last resort, therefore as other programs become available that provide prescription assistance, MIDAP reserves the right to require potentially eligible persons to apply for and pursue those other programs.

MIDAP 2015 Federal Poverty Guidelines (450%)		
Persons in Household	**Monthly Income**	**Annual Income**
1	$4,413.75	$52,965
2	$5,973.75	$71,685
3	$7,533.75	$90,405
4	$9,093.75	$109,125
5	$10,653.75	$127,845
6	$12,213.75	$146,565
7	$13,511.25	$162,135
8	$15,333.75	$184,005

An applicant will not be eligible for MIDAP if they are:

- Eligible for or are receiving benefits from Medicaid/Healthy Michigan Plan and/or the Adult Medical Program/Adult Benefits Waiver (AMP/ABW) is not eligible for MIDAP
- Eligible for both Medicaid and Medicare and/or considered dual eligible under both Medicaid and Medicare is not eligible for MIDAP
- A resident outside the State of Michigan

2015 MIDAP Application Instructions

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1. **Have you been on MIDAP before?** If yes, enter your MIDAP Member ID

2. **Legal Full Name:** Enter your LEGAL LAST NAME, LEGAL FIRST NAME, LEGAL MIDDLE NAME, MAIDEN NAME (if applicable) and ALIAS (if applicable).

3. **Marital Status:** Select one of the following: Married, Single, Divorced, or Widowed.

4. **Address:** Enter your ADDRESS (including any Post Office box, Apartment number, or lot number) as well as the CITY, STATE, ZIP CODE and COUNTY OF RESIDENCE.

   You must provide your proof of residency. This can include any of the following:
   - Current State of Michigan identification card or Driver's License
   - Utility bill in individual's name showing address
   - Benefits award letter (Department of Human Services (DHS)/Social Security Administration (SSA) with individual's name and address
   - Lease or mortgage in individual's name showing address
   - Voter registration card

   NOTE: MIDAP will use the address that you list on your application as the address to contact you via the United States Postal Service.

5. **Phone Number:** Enter the phone number that you would like MIDAP to use to contact you.

6. **Social Security Number:** Enter your number as it is listed on your Social Security card (###-##-####). Failure to provide may delay the processing of your application.

7. **Date of Birth:** Enter the month, date and year of your birth (MM/DD/YYYY).

8. **Sex at Birth:** Indicate your BIOLOGICAL SEX at BIRTH: Male or Female

9. **Current Gender**: Indicate your CURRENT GENDER by filling in or putting a √ next to the appropriate gender identity. **NOTE:** Pharmacies require gender information (Male, Female or Transgender) to allow you to fill your prescriptions. If you select transgender, please answer transgender status.

10. **Transgender Status** and √ the gender identification that you have communicated to the pharmacy to ensure you are able to pick up your medications upon program approval.

11. **Are you currently pregnant?** Indicate whether you are pregnant at the time of applying for MIDAP. If yes, specify your approximate due date (MM/DD/YYYY).

12. **Race:** Select all that apply: American Indian/Alaska Native, Black/African American, White, Native Hawaiian/Pacific Islander or Asian.
    - Black or African American—A person having origins in any of the black racial groups of Africa.
    - White—A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
    - Native Hawaiian/Pacific Islander—One or more of the subcategories must be chosen:
        1. Native Hawaiian

2. Guamanian or Chamorro
3. Samoan
4. Other Pacific Islander

- Asian—One or more of the subcategories must be chosen:
    1. Asian Indian
    2. Chinese
    3. Filipino
    4. Japanese
    5. Korean
    6. Vietnamese
    7. Other Asian

13. **Ethnicity:** Select one of the following: Hispanic, Non-Hispanic or Unknown.
    - **Hispanic/Latino Subgroup:** Indicate your Hispanic/Latino(a) subgroup. One or more categories may be selected:
        1. Mexican, Mexican American, Chicano/a
        2. Puerto Rican
        3. Cuban
        4. Another Hispanic, Latino/a or Spanish origin

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14. **Estimated HIV Positive Date/Diagnosis:** You will need to enter an estimated date if you don't know the exact date (MM/DD/YYYY).

15. **Name of HIV Test (if known):** Western Blot, Nucleic Acid Amplification Test (NAAT), Multi-spot, Immunoassay (IA) or 2 Dual Immunoassay positive results for HIV (assays must be from different manufacturers). If you do not know the name of the HIV test that was given, leave this space blank.

16. **Estimated AIDS Positive Date:** Enter an estimated AIDS positive date (MM/DD/YYYY), if applicable.

17. **HIV Stage of Disease:** Check one of the following:
    - HIV-positive, AIDS status unknown- Diagnosed with HIV. It is not known whether or not the person has AIDS.
    - HIV-positive, not AIDS- Diagnosed with HIV but has not been diagnosed with AIDS
    - CDC defined-AIDS (3rd Stage HIV) - HIV-infected individual who meets the CDC AIDS case definition for an adult or child. For additional information, you can go to the following website: http://www.cdc.gov/hiv/statistics/recommendations/terms.html
    - Unknown- A client whose HIV/AIDS status is unknown or was not reported.

18. **Household Size and Income:** Household size is every person that you claim on your current Federal Internal Revenue Service (IRS) tax submission. For example, a household would be two if you claim yourself and one child on your current Federal IRS tax submission.

    - **Income:** Indicate any income you receive by placing a √ next to each of the appropriate source(s) and then write in the gross (pre-tax) total monthly amount that you receive from the indicated source(s). You must also include the gross annual income (pre-tax amount) that you receive.

- **If you are Self Employed:** Submit a copy of your 2014 – 1040 Federal tax forms, signed and dated by a licensed preparer, or a signed and dated 2014 – 1040 Federal tax form, signed by you, along with a copy of your Schedule E form, as proof of income.

- **No income:** If you do not receive any income, you must apply for Medicaid/Healthy Michigan Plan and/or the Adult Medical Program at your local county Department of Human Services (DHS) office prior to submitting your application to the MIDAP. Include the date your application was submitted to DHS. If you have any questions please call the MIDAP office at 1-888-826-6565, or call Ken Pape at DHS, 1-877-342-2437.

To apply for the **Healthy Michigan Plan**, you can visit your local Department of Human Services Department, call 1-855-789-5610 or apply online at www.healthymichiganplan.org

- **Submit Proof of Income:** The previous year's W-2 form must be submitted with your application along with one or more of the following options (unless you are self-employed, see below):
  - The most recent month's pay stubs (a 4 week, 30 day period)
  - Notice of award for SSI or SSDI
  - Notice of award for DHS/SSA
  - Notarized statement from an employer showing gross pay for that last 30 days
  - Unemployment benefits award
  - Corrections release papers within 30 days of release
  - Declaration of no income
  - Declaration of support

19. **Proof of HIV Status:** To meet reporting requirements as a condition of grant funding, all MIDAP members are required to provide proof of their HIV+ status one time at initial enrollment. After this is received, all members must submit their most recent HIV viral load updates as part of the six month recertification process and both their CD4 and HIV viral load updates as part of the annual recertification and at other times as required by MIDAP or as required as a condition of grant funding.

    New Members: At initial enrollment you must provide proof of HIV+ status in one or more of the following ways:
    - **Laboratory Generated (computer generated):** Western Blot, Nucleic Acid Amplification Test (NAAT), Multi-spot or Immunoassay (IA) test with a positive or reactive result.

    - **HIV/RNA Viral Load:** must be detectable beyond the specific tests lowest reference range. If lab reports are not yet available as described above, an original doctor's signature or his/her designee (as allowed under Michigan law) on the application is acceptable, with your lab results to follow within 30 days.

    - If you are signing on behalf of a physician, you must indicate on the application the name of the physician and their NPI number.

LABORATORY TESTING

MIDAP provides members with no insurance assistance with CD4, viral load, and genotype (resistance) testing.

In order to access this assistance, the applicant must communicate their MIDAP eligibility information to their physician prior to blood draw and all samples must be sent to the State of Michigan lab to be analyzed. Any questions regarding this process can be directed to the MIDAP office at 1-888-826-6565.

Any laboratory testing done in a hospital lab or sent to other diagnostics centers or laboratories is **NOT** eligible for assistance from MIDAP.

MIDAP is not responsible for the cost incurred as part of the blood draw.

PLEASE NOTE: Due to the fragile nature of blood samples and the requirements of shipping, limited lab draw hours may be enforced. Please contact your medical provider for more information

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20. Prescription Coverage/Medical Insurance Coverage

If you have prescription coverage/medical insurance through any of the following that require you to pay a copay and/or deductible at the pharmacy, check all that apply and provide the additional required information. Attach a copy of your insurance card for accuracy.

- Employer Sponsored, Private Policy or Qualified Health Plan
- Medicare Part A/B
- Medicare Part D or Advantage
- Veteran's Administration Benefits (VA)
- No Insurance
- Other

If not, check no and move on to the MIDAP Coverage Section.

Medicare Eligibility

You are eligible for Medicare if you:

- Or your spouse worked for at least 10 years in Medicare-covered employment
- Are 65 years or older
- Are a citizen or permanent resident of the United States

If you aren't 65 yet, you might also qualify for coverage if you have a disability or with End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant).

a) **You must apply for the Low Income Subsidy (LIS)/Extra Help Program.** This program is available to assist eligible Medicare recipients with the out-of-pocket expenses associated with Medicare Part D Prescription Plan (PDP)/Medicare Rx. You can apply for this program online at www.ssa.gov. Upon doing so, print the confirmation of LIS/Extra Help application page and submit it with your MIDAP application. Applications may be obtained by calling the Social Security Administration at 1-800-772-1213, or by contacting the MIDAP office at 1-888-826-6565.

Please keep in mind that if you have previously applied for the LIS/Extra Help program that you must reapply annually to determine your ongoing eligibility for assistance with your out-of-pocket Medicare D expenses.

When you receive your approval/denial letter for LIS/Extra Help, **file it in a safe place**. As a Medicare recipient applying for prescription coverage from MIDAP, you will need to provide a copy of your approval/denial letter for LIS/Extra Help along with your MIDAP application.

If you are approved for **partial** LIS/Extra Help you will have **reduced** out-of-pocket expenses. MIDAP will assist with the remaining out-of-pocket expenses (reduced premiums, deductibles, and coinsurance).

If you are **denied** for the LIS/Extra Help, MIDAP will assist with your out-of-pocket costs (premiums, deductibles, and coinsurance) as long as you meet **all** other eligibility criteria.

Please note: Dual Eligible (Medicaid and Medicare) individuals are not eligible for assistance from the MIDAP.

b) All individuals with Medicare must enroll in a Medicare Prescription Drug Plan (PDP)/Medicare Rx plan. You can enroll in a plan by contacting the plan directly, or on the web at www.medicare.gov. If you need assistance reviewing Medicare plans, you may contact your HIV case manager, or call either the Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174 or 1-800-MEDICARE. The MIDAP staff is also available to assist in researching plans at 1-888-826-6565.

Please note that Medicare eligible individuals may only enroll in a PDP during the following times:

- Up to 3 months prior to when you become Medicare eligible and up to 3 months after you first became Medicare eligible.
- During the annual open enrollment period usually toward the end of the calendar year.

If you have already enrolled in a prescription drug plan, please write the PDP information on your application.

21. MIDAP Coverage: Please indicate the type of prescription coverage you are requesting (Check the most appropriate coverage and check ONLY one)

a) Full Drug Assistance: This type of assistance indicates that you are requesting that MIDAP pay for your medications in full on your behalf because you do not have AND are not eligible for insurance and/or prescription coverage from any other source. If approved for this coverage, MIDAP would pay the contracted pharmacy rate for approved formulary medications only.

You must apply for Medicaid and/or the Adult Medical Program at your local county Department of Human Services (DHS) prior to submitting your MIDAP application.

Please do not submit the MIDAP application until your Medicaid application has been reviewed by your DHS worker and is either pending, denied, or in Medicaid deductible status. Applicants must have applied for Medicaid within 90 days of submission of application. If you have any questions please call the MIDAP office at 1-888-826-6565 or call Ken Pape at DHS at 1-877-342-2437

b) Copay Assistance (Private, QHP, Employer-Sponsored, COBRA, VA): This type of assistance indicates that you are requesting that MIDAP pay for your out of pocket copays for your prescriptions. This is the amount YOU would usually pay at the pharmacy. If approved for this coverage, MIDAP would act as your secondary prescription coverage and pay your copays on your behalf after your insurance pays for their portion of the prescription claim.

If you do not have an income, and report -0- in the household size and income section, you must apply for Medicaid/Healthy Michigan Plan or the Adult Medical Program at your local county Department of Human Services (DHS) office.

c) Copay Assistance (Medicare Part D, Medicare Advantage Plan-Part C): This type of assistance indicates that you are a Medicare beneficiary requesting that MIDAP pay your out-of-pocket expenses associated with your Medicare Part D prescription benefit. This is any amount that your Medicare Part D plan requires you to pay in the form of a copay or deductible after your Part D plan pays the portion they are responsible for AND after any Low Income Subsidy/Extra Help assistance is applied to your prescriptions, if applicable. If approved for this coverage, MIDAP would act as your secondary prescription coverage and pay your copays on your behalf after your insurance pays for their portion of the prescription claim.

NOTE: Failure to sign and date the consent page will result in a delay of processing and access to medications.

For copies of any MIDAP forms please see the website at www.michigan.gov/dap

If you need assistance filling out the application, please contact your case manager or the MIDAP office at 1.888.825.6565

For a list of AIDS Service Organizations, case management, clinic and testing locations, please call 1.800.872.2437

www.michigan.gov/survivehiv